PSY47

VARIATION IN PRIMARY CARE CONSULTATION COSTS AMONG NON-CANCER PATIENTS TREATED WITH CHRONIC OPIOID ANALGESIA IN THE UNITED KINGDOM

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OBJECTIVES: Chronic pain affects around five million people in the UK. Non-injectable, strong opioid analgesia is increasingly being used to manage chronic pain but this requires careful management to avoid common adverse effects. This study aimed to characterise variation in primary care consultation costs as a function of analgesic stability among patients treated with long-term, non-injectable opioids. **METHODS:** Cases with at least 6-months' observation prior to opioid analgesia and no history of cancer were extracted from The Health Improvement Network database (THIN), a source of anonymised patient-level data from UK general practice. The number of different, strong opioid drugs (British Pain Society defined) prescribed to each patient during their first year of chronic opioid analgesia was used a proxy measure of analgesia stability. Primary care consultations were costed using a standard tariff at £UK2007. **RESULTS:** A total of 21,261 cases were studied, of which 54% were female and the mean age at initiation of opioid analgesia was 62 years (sd 11). Prior to initiating strong opioid analgesia the annual, average, total cost of consultations with primary care health practitioners was £188 (95%CI £184 to £191). After initiation of opioid analgesia, patients treated with a single drug incurred annual consultation costs of £546 (£537 to £554) per year on average, and these costs increased sharply with each additional opioid: £706 (£686 to £726), £836 (£789 to £884), and £975 (£818 to £1132; $p_{ANOVA} < 0.001$) for two, three, and four or more opioids, respectively. The majority of consultations (84%) were with general practitioners in the surgery. **CONCLUSIONS:** The occurrence of persistent pain was associated with a considerable increase in the rate and the related financial cost of consultations with health professionals in primary care. Furthermore, a substantial cost gradient was evident among patients who failed to be managed with stable opioid monotherapy during their first year of opioid analgesia.

PSY48

RESOURCE USE AND COSTS OF THE GASTRIC BYPASS SURGERY VERSUS CLINICAL TREATMENT FOR OBESE PATIENTS WITH COMORBIDITIES UNDER THE BRAZILIAN PRIVATE HEALTH CARE SYSTEM

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OBJECTIVES: To assess use of resources and costs of the surgical versus clinical treatment for obese patients with comorbidities, under the Brazilian private health care system. **METHODS:** In order to estimate the differences of resource use and costs related to surgery versus clinical treatment one panel of specialists was conducted to raise up the resources necessaries for the treatment from pre-operatory evaluation to the last medical visit after 5 years. For the clinical treatment group we assumed a conservative scenario where the complications are not considered. a micro costing technique based on public price lists was applied to value the resources from the panel considering only direct medical costs. a discount rate of 5% was assumed. **RESULTS:** For the first year the total costs per patient for the surgically treated group were R$14,547, for the open approach and R$31,415 for the laparoscopic approach (pre-operatory assessment R$2,009, inpatient costs R$2,728 versus R$2,493, procedure R$7,233 versus R$24,478, complications R$323 versus R$181 and the clinical follow up R$2,254 for both) and for the clinical treated group the total costs per patient was R$7,545 where R$5,062 occurred due to the obesity management (diet, consults, and drugs for weight management) and R$2,488 for comorbidities (drugs, consults and exams for Diabetes TII, hypertension and hypercholesterolemia). After the first year the surgically treated group had R$1690 of annually costs for the follow up versus R$3290 for the clinical treatment group. After 5 years the total costs were R$22,284 and R$39,153 for open and laparoscopic surgery and R$19,217 for the clinical treatment. **CONCLUSIONS:** Findings suggest that gastric bypass can reduce the use of resources and costs related to the management of obese patients, under the Brazilian private health care system.

SYSTEMIC DISORDERS/CONDITIONS – Patient-Reported Outcomes Studies

PSY49

PATIENTS PREFERENCES IN OVERWEIGHT AND OBESITY THERAPY WITH DISCRETE CHOICE EXPERIMENTS

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OBJECTIVES: Overweight is associated with increased risk of morbidity, mortality and appears to adversely affect health-related quality of life (HRQOL). Though advances in obesity therapy can be observed, the long-lasting outcome is dissatisfying. This study aims to investigate patients' preferences of overweight and obesity therapy in the setting of rehabilitation. **METHODS:** Qualitative and quantitative methods were applied to identify key attributes. Literature review, focus groups (N = 44) and expert interviews (N = 5) were conducted to elicit relevant attributes and endpoints. a total of 64 possible therapy items were surveyed (N = 201) using a classic rating scale in 5-point Likert format. Psychometric tests (frequency, factor analysis, reliability tests) were used to verify the structure of relevant attributes. Discrete choice experiments were developed using a fractional factorial design in fold over method. For statistical data analysis, we used a random effect logit models for the DCE. Finally a self-administered survey, measuring preferences, was conducted in Germany in 2009 (n = 110). **RESULTS:** A total of 110 patients responded of which 51,82% were male, mean age 53,05 years, mean BMI 33,54 kg/m^2 (SD 7,73) answered the questionnaire. The highest relevance for the respondents' selection was the aspect of care coordination (Item 6: Coefficient 1.473; SE 0.185) and individual therapy (Item 4: Coefficient 1.446; SE 0.188). The aspect of infrastructure of care was less relevant in the discrete choice experiment. All included attributes lead to significant coefficients. **CONCLUSIONS:** Weight reduction therapy should enable patients to receive a structured, coordinated and predefined therapy that is individualized based on personal needs, behaviour and circumstances. Patients are willing to abandon infrastructural quality for getting better coordination, structure in there therapy. Further research is needed to distinguish the possible interpretations of the presented preference dimensions, the possibility of including them into weight loss programs and to take notice of heterogeneity within patient population in weight loss programs.

PSY50

HEALTH-RELATED QUALITY OF LIFE, HEALTH UTILITIES, AND WORK PRODUCTIVITY ASSOCIATED WITH SPECIFIC OBESITY-RELATED COMORBIDITIES

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OBJECTIVES: The study assessed whether, beyond general risks from obesity-related comorbidities, specific comorbidity types were associated differentially with impairments to health-related quality of life and work productivity. **METHODS:** Data were from the European 2008 National Health and Wellness Survey of German, Spanish, Italian, UK, and French adults. Logistic regressions identified significant predictors of presence vs. absence of obesity (BMI ≥ 30) among 62 medical conditions, for 52,206 respondents with valid BMI data (of 53,524 total). Significant predictors were then submitted to a principal component analysis (PCA) to identify obesity-related components accounting for the most variance. Conditions loading most highly on the resulting components were used to predict the following outcomes for all 10,391 obese respondents, using multiple regressions: physical (PCS) and mental (MCS) component summary scores from the SF-12v2 quality of life instrument, health utilities (SF-6D), and percentage overall work impairment (WPAI). Comparisons were against obese respondents with none of the PCA-identified conditions, controlling for the other conditions. **RESULTS:** Logistic regressions identified 35 obesity predictors that reduced to 9 PCA components with one condition loading prominently on each: hypertension, high cholesterol, arthritis, angina, thyroid condition, diabetes, chronic bronchitis, psoriasis, and urinary incontinence. All conditions except psoriasis predicted PCS reductions ranging from 1.22 (with presence of angina) to 9.02 (arthritis), $ps < 0.001$. All except diabetes and angina, and arthritis and hypertension (associated with MCS increases), predicted MCS reductions ranging from 0.70 (cholesterol) to 4.11 (incontinence), $ps < 0.05$. All except angina predicted health utilities reductions ranging from 0.011 (hypertension) to 0.077 (incontinence), $ps < 0.001$. Among 5,242 employed respondents, all except angina and psoriasis predicted overall work impairments of 2.11% (hypertension) to 12.48% (bronchitis), $ps < 0.05$. **CONCLUSIONS:** Obese EU respondents differed significantly in quality of life and productivity impairments, based on both presence and specific types of comorbidities. These findings can help guide interventions among obesity-related conditions.

PSY51

STATED PREFERENCES OF PHYSICIANS AND CHRONIC PAIN SUFFERERS IN THE USE OF CLASSICAL STRONG OPIOIDS

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OBJECTIVES: Treating chronic pain involves difficult trade-offs between the goals of pain relief and avoidance of side-effects, but evidence is scarce on relative perspectives of physicians and pain sufferers. We studied each group's preferences concerning classical strong opioids in France, Germany, Italy, Spain, Sweden and the UK. **METHODS:** In online, discrete choice experiments (DCE), chronic pain sufferers (n = 242) and physicians (n = 270) chose between hypothetical profiles or an opt-out in 15 choice tasks. Profile descriptions were based on attributes elicited in focus groups with 84 sufferers and semi-structured interviews with 11 physicians. Models were specified by multinomial logit and individual respondent part-worths were estimated by hierarchical Bayesian regression. **RESULTS:** All main-effects, but no interactions, were significant. Sufferers ranked nausea, pain impact, energy, alertness and constipation; and physicians ranked pain response, CNS effects, nausea, dosage form and constipation in descending order of importance. Sufferers were unwilling to incur severe side-effects to relieve pain, opting out in approximately half of the choice tasks, while physicians were always willing to trade between profiles. The models predicted physicians' choices well but those of pain sufferers less so. No age, sex or country effects were seen but stronger preferences were expressed by the minority (15%) of physicians treating non-cancer pain, and by the 55% of sufferers who had ever discontinued chronic pain medication and the 41% who reported extreme pain and